SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Filing at a Glance

Company: IA American Life Insurance Company

Product Name: Family Solution	SERFF Tr Num: APLE-127009065	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 47836
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: GL212	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Linda Dymacek, Laci Hunter, Lisa Kaiser	Disposition Date: 01/31/2011
	Date Submitted: 01/28/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Family Solution	Status of Filing in Domicile: Not Filed
Project Number: GL212	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/31/2011
	State Status Changed: 01/31/2011
Deemer Date:	Created By: Linda Dymacek
Submitted By: Laci Hunter	Corresponding Filing Tracking Number:

Filing Description:

The above referenced forms are being submitted for your consideration and approval. The forms will not replace any existing policy forms currently in use. The policy contains no unusual or controversial features or language that deviate from normal insurance industry standards. This policy will be offered to individuals in the general public through licensed agents.

The Level Term Insurance Rider LT301 will be used with policy GDWL103 approved from your department on 1/14/2011 under APLE-126970484.

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Children's Insurance Agreement CIB304AR will be used with Policy GDWL102 approved by your department on 1/5/2011 under APLE-126945174 and also used with previously approved policy, GDWL103.

Family Plan Life Insurance Application GL212 will be used with the previously approved Policy GDWL103.

This product will be marketed without an illustration. The product does not have non-guaranteed elements.

Company and Contact

Filing Contact Information

Lisa Kaiser, Compliance Assistant
17550 N. Perimeter Drive
Suite 210
Scottsdale, AZ 85255-0131

lisa.kaiser@iaplife.com
888-473-5540 [Phone] 5532 [Ext]
480-563-0252 [FAX]

Filing Company Information

IA American Life Insurance Company
17550 N. Perimeter Dr.
Suite 210
Scottsdale, AZ 85255-0131
(480) 473-5540 ext. [Phone]

CoCode: 91693
Group Code: 315
Group Name: Industrial Alliance Group
FEIN Number: 13-3036472

State of Domicile: Georgia
Company Type: LAH
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	3 forms X $50
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
IA American Life Insurance Company	$150.00	01/28/2011	44182529

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/31/2011	01/31/2011

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Disposition

Disposition Date: 01/31/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Form	Level Term Insurance Rider		Yes
Form	Children's Insurance Agreement		Yes
Form	Family Plan Life Insurance Application		Yes

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Form Schedule

Lead Form Number: GL212

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LT301	Certificate Amendment, Insert Page, Endorsement or Rider	Level Term Insurance Rider	Initial		55.000	LT301.pdf
	CIB304	Certificate Amendment, Insert Page, Endorsement or Rider	Children's Insurance Agreement	Initial		50.000	CIB304.pdf
	GL212AR	Application/Enrollment Form	Family Plan Life Insurance Application	Initial		45.000	GL212AR.pdf

AMERICAN™
LIFE INSURANCE COMPANY
a stock company

Customer Service Center
P.O. Box 2549, Waco, TX 76702-2549
Toll Free: 866-363-3290

LEVEL TERM INSURANCE RIDER

THE COMPANY WILL PAY to the Beneficiary the amount of Term Insurance as shown herein upon receipt of due proof that the death of the named individual as shown herein occurred: (a) prior to the Expiry Date of this Rider; and (b) while the Rider was in force.

Any benefits payable under this Rider will also include:

1. the portion of any premium paid which applies to a period beyond the month of death of the Insured, unless the premium was waived under the additional agreement providing waiver of premiums; less;

2. any portion of a premium due and unpaid which applies to a period prior to the date of death of the Insured.

TERMINATION. This Rider shall terminate:

1. on the anniversary date twenty years from the date of issue or on the anniversary nearest the Insured's 70th birthday if this occurs prior to the twentieth anniversary.

2. when the grace period expires for payment of any premium in default on the Policy or this Rider; or

3. when the Policy terminates.

This Rider may be terminated at any time by the Owner's written request. The Policy must be sent with the request for proper endorsement.

POLICY PROVISIONS. Unless expressly stated, nothing contained in this Rider will change, waive or extend the terms of the Policy. The additional benefits that this Rider provides will not be considered when policy loan values are determined. If the provisions entitled "Loan Provisions", "Nonforfeiture Values", and "Table of Nonforfeiture Values" are included in the Policy, they shall not apply to this Rider

CONSIDERATION. This Rider is issued in consideration of: (a) the application, a copy of which is attached to the Policy; and (b) payment of the premium for this Rider shown on page 3 of the Policy. Such premium is payable until this Rider is terminated. If a premium is tendered to and accepted by the Company after coverage under this Rider has ceased, the Company's acceptance of the premium shall not be deemed a waiver of the termination of coverage. The Company will refund such premiums.

SIGNED at the Home Office of the Company as of the Agreement Date.

Secretary

President

Date: _____

IA AMERICAN™ LIFE INSURANCE COMPANY
a stock company

[Customer Service Center
P.O. Box 2549, Waco, TX 76702-2549
Toll Free: 800-736-7311]

CHILDREN'S INSURANCE AGREEMENT

IA AMERICAN LIFE INSURANCE COMPANY has issued this supplemental agreement (the "Agreement") as a part of the policy (the "Policy") to which it is attached. The provisions of the Policy apply to this Agreement except where such provisions conflict with the express provisions hereof, in which event the provisions of the Agreement will control. Terms defined in the Policy which are used herein shall have the meaning specified in the Policy. The term "Insured", as used herein means the person who is insured under the policy to which this Agreement is attached.

THE COMPANY WILL PAY the amount of Children's Insurance shown on page 3 of the Policy upon receipt of due proof that the death of a Dependent Child occurred: (a) while this Agreement is in force; and (b) prior to the policy anniversary nearest the child's 25th birthday; and (c) prior to the Expiry Date of this Agreement. The Expiry Date of this Agreement is the policy anniversary nearest the Insured's attained age 65.

Any benefits payable under this Agreement will also include:

1. the portion of any premium paid which applies to a period beyond the month of death of the child insured under this Agreement, unless the premium was waived under the additional agreement providing waiver of premium; less

2. any portion of a premium due and unpaid which applies to a period prior to the date of death of said child.

DEPENDENT CHILD means a child, stepchild, or legally adopted child of the Insured, who is 15 or more days old; that is, the child has survived for not less than 360 hours, but has not reached the policy anniversary nearest that child's 25th birthday. Such child must either be: (a) named in the application for this Agreement and not have reached his or her 18th birthday on the date of such application; or (b) acquired by the Insured after the date of the application but before the child's 18th birthday.

BENEFICIARIES. The beneficiary for the amount payable upon the death of a dependent child will be:

1. the Insured if then living; otherwise
2. the child's estate

NO PREMIUMS AFTER DEATH OF INSURED. On the death of the Insured, except as provided in the Suicide paragraph, any insurance under this Agreement on the life of a Dependent Child will continue in force, without further payment of premiums, to the earlier of: (a) the Expiry Date of the Agreement; or (b) the policy anniversary nearest such child's 25th birthday.

CONVERSION OF INSURANCE ON DEPENDENT CHILDREN. If the insurance on a Dependent Child expires while this Agreement is in force, such insurance may be converted, without evidence of insurability, subject to the following:

1. Proper written application for the converted policy must be made to the Company at its Home Office. Such application must be received by the Company no later than the date when insurance under this Agreement would expire: however, in the event of the Insured's death, such application must be made within 31 days after such death. The Date of Issue of the converted policy will be the date when the insurance under this Agreement would expire;

2. The converted policy shall become binding upon the Company only upon payment of the first premium for such policy. The Company must receive the first the premium: (a) no later than 31 days after the date when insurance under this Agreement would expire; and (b) while the person to be insured under such policy is living;

3. The converted policy will be for an amount up to five times the amount of insurance under this Agreement on such child;

4. The converted policy will be on any plan of Life or Endowment insurance then issued by the Company, except Term Insurance. The policy will be subject to the Company's rules regarding minimum policy amounts. Conversion may not be made for an amount or plan of insurance prohibited by law. Premium rates for the converted policy will be based on: (a) the then attained age of such child; and (b) the same mortality classification as this Agreement; and

5. The converted policy shall not provide for Accidental Death or Waiver of Premium Disability Benefits unless such benefits are: (a) agreed to by the Company; and (b) subject to the requirements the Company may make at the time of conversion.

If death of a Dependent Child occurs within 31 days after the insurance upon the life of such child expires but prior to the application for conversion, the Company will pay a death benefit equal to the amount of insurance expiring on the life of such person. Such benefit will be paid as if the insurance had not expired.

THE ADDITIONAL BENEFIT that this Agreement provides shall not be considered when policy loan and nonforfeiture values are determined. Unless expressly stated, nothing contained in this Agreement will change, waive, or extend the terms of the Policy.

REINSTATEMENT. When a premium is not paid before the end of its grace period, this Agreement can be reinstated:

1. subject to all the provisions of the Policy to which this Agreement is attached relating to reinstatement;

2. with evidence of insurability acceptable to the Company of all persons to be insured; and

3. upon concurrent reinstatement of the Policy to which this Agreement is attached.

Upon reinstatement, no benefit will be paid because of the death of any Dependent Child formerly insured under this Agreement if such death occurred: (a) after the end of the grace period; and (b) prior to the date of reinstatement.

TERMINATION. Unless otherwise specified in this Agreement, this Agreement shall terminate upon the earlier of:

1. on the Expiry Date of this Agreement;

2. the death of the Insured;

3. upon the due date of a premium for this Agreement which is not paid before the grace period for the payment of such premium expires as provided in the Policy; or

4. when the Policy is surrendered, cancelled or otherwise terminated.

This Agreement may be terminated at any time by the Owner's written request. The Policy must be sent with the request for proper endorsement.

SUICIDE. If the Insured or a Dependent Child dies by suicide, while sane or insane, within two years from the Agreement Date, the liability of the Company under this Agreement will be limited to the amount of premiums paid for this Agreement. When the laws of the state in which this Policy is delivered require less than this two year period, the period will be as stated in such laws. The coverage of all Dependent Children shall terminate on the date of the suicide of the Insured.

INCONTESTABILITY. This Agreement will be incontestable after it has been in forced two years from the Agreement Date. The terms and conditions of the incontestability provisions of the Policy shall apply to this Agreement in that such provisions also relate to any insured Dependent Child.

CONSIDERATION. This Agreement is issued in consideration of: (a) the application, a copy of which is attached to the Policy; and (b) payment of the premium for this Agreement shown on page 3 of the Policy. Such premium is payable: (a) until the Agreement is terminated; or (b) for the period stated in the Policy, if such period is shorter. If a premium is paid after coverage under this Agreement has ceased, the Company's acceptance of the premium shall not be deemed a waiver of the termination of coverage. The Company will refund such premiums.

The effective date of this Agreement (the "Agreement Date") is the Policy Date, unless a different date is shown below.

SIGNED at the Home Office of the Company as of the Agreement Date.

Secretary

President

Date: _____

IA AMERICAN™ LIFE INSURANCE COMPANY

www.iaamerican.com

IA AMERICAN LIFE INSURANCE COMPANY
P.O. BOX 2549, WACO, TX 76702-2549
866-363-3290

FAMILY PLAN
LIFE INSURANCE APPLICATION
(Please print in black ink)

Telephone Case No:_____

Proposed Insured _____ (First) (Middle) (Last)

Address (No. & Street)_____

City_____ State _____ Zip Code _____

Phone interview completed (Age 40-49) ☐ Yes ☐ No

_____ Phone _____ Best time to call ☐ am ☐ pm

E-mail Address _____

Sex	Date of Birth	Age	State of Birth	SS#	Height	Weight	Occupation
☐ Male ☐ Female	Mo. Day Yr / /			DL#	ft in	lbs	

Owner: Name _____ SS#_____ Address:_____

Payor: Name _____ SS#_____ Address:_____

Primary Beneficiary	Relationship	Contingent Beneficiary	Relationship

Plan: ☐ Immediate Plan (Issue Age 0-49) Automatic Prem. Loan Elected ☐ Yes ☐ No

During the past 12 months have you used tobacco in any form (excluding occasional pipe and cigar use)? ☐ Yes ☐ No **Face Amt $**

Rider: ☐ Children's Insurance Agreement $_____ ☐ ADB $ ☐ Other

☐ Spouse Term Rider $ _____ Name: _____

Sex	Birthdate	Height	Weight

Mode: ☐ Bank Draft ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ Draft 1st premium on Requested Date Modal Premium $

CWA: ☐ E-Check Immediate 1st Prem ☐ Collected $

Policy Date Request: / /

Do you have any existing life or disability insurance or annuity contract? ☐ Yes ☐ No Company

Will you replace an existing life or disability insurance policy or an annuity? ☐ Yes ☐ No Policy # Amount of Coverage $

Physician: Name City/State Phone:

HEALTH INFORMATION - Answer Questions for all Proposed Insureds.

	PROPOSED INSURED		*PROPOSED SPOUSE*	
	YES	NO	YES	NO
1. Have you been medically treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related disorder or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐	☐	☐
2. **Within the past 24 months,** have you been convicted of any felony, or had your driver's license suspended or revoked, or been convicted of driving under the influence of alcohol or drugs, or used illegal drugs or abused alcohol or drugs, or had or been recommended to have treatment or counseling for alcohol or drug abuse?	☐	☐	☐	☐
3. **Within the past 12 months,** have you been on probation, parole, or been prohibited from actively working full time (30 hours or more per week) at your regular occupation due to any illness, injury, or health related problem, or **currently** disabled?	☐	☐	☐	☐
4. **Within the past 5 years** have you been medically diagnosed or treated, or taken medication for internal cancer, melanoma, Hodgkin's disease, or lymphoma?	☐	☐	☐	☐
5. Have you been medically diagnosed, treated, or taken medication for diabetes prior to age 21, or do you currently take insulin shots, or been medically diagnosed with diabetes combined with a medical history of any of the following: retinopathy, nephropathy, neuropathy, insulin shock, or diabetic coma?	☐	☐	☐	☐
6. Have you been medically diagnosed, treated, or taken medication for:				
a. heart or circulatory disease or disorder, stroke, congestive heart failure, cardiomyopathy, heart valve disease, sickle cell anemia, leukemia, hemophilia, Marfan's syndrome, cystic fibrosis, muscular dystrophy, Huntington's disease, motor neuron disease, systemic lupus (SLE), connective tissue disease?	☐	☐	☐	☐
b. mental retardation, bi-polar or schizophrenia, Down's syndrome, liver or kidney failure or renal insufficiency (including dialysis), had an amputation caused by disease or had or been advised to have an organ transplant?	☐	☐	☐	☐
7. Have you been medically diagnosed, treated, or taken medication for:				
a. high blood pressure prior to age 30, diabetes prior to age 39 or taking 3 or more medications for high blood pressure?	☐	☐	☐	☐
b. rheumatoid arthritis, paralysis of two or more extremities or any neuro-muscular disease (including, but not limited to cerebral palsy, multiple sclerosis, or Parkinson's disease), liver disease, Hepatitis C, chronic hepatitis or chronic pancreatitis, Crohn's disease or ulcerative colitis?	☐	☐	☐	☐
8. **Within the past 12 months** have you had surgical treatment for morbid obesity, or been declined for life insurance coverage or had any diagnostic testing, surgery or hospitalization recommended by a medical professional which has not been completed or for which the results have not been received?	☐	☐	☐	☐
9. **Within the past 3 years** have you been medically diagnosed or treated, or taken medication for chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), irregular heart beat, seizures, blood clot, aneurysm?	☐	☐	☐	☐

If all questions 1 through 9 are answered "No" the Proposed Insured and Spouse, if applicable, are eligible for Immediate Coverage.

GL212AR

NOTICE
Printed in compliance with Public Law 91-508

Thank you for considering IA American Life Insurance Company of for your insurance needs. This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation and personal characteristics. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. IA American Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

IA American Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

CHILDREN COVERAGE ONLY Children Proposed for Insurance (any additional children should be listed on a separate sheet):

Proposed Insured Name	Ht.	Wt.	Sex	Birthdate	Proposed Insured Name	Ht.	Wt.	Sex	Birthdate

CHILDREN HEALTH STATEMENT—To the best of my knowledge and belief, none of the children listed above for coverage have been treated for or told by a physician that they have or had any of the following medical conditions: Hypertension, heart or circulatory disorder, malignancy in any form, diabetes, sickle cell anemia, seizures, Down's Syndrome, cystic fibrosis, cerebral palsy, hydrocephalus, paralysis, or hospitalized for asthma or any respiratory disorder in past 12 months.

List the names of the children that are exceptions to the CHILDREN HEALTH STATEMENT. ***Children listed as an exception are excluded from the Children's Insurance Agreement Rider.*** **Exceptions are:**_____

AGREEMENT—I agree with IA American Life Insurance Company (the Company) as follows: (1) To the best of my knowledge and belief, all answers and statements contained in this application are true, complete and correctly recorded; and (2) This application and any policy issued on the basis of such application shall form the entire contract; and (3) No change in this contract shall be effected without my written consent with regard to: (a) the amount of insurance; (b) age at issue; (c) classification of risk; (d) plan of insurance; or (e) benefits. If this application is declined by the Company, I will accept the return of any premium paid. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may be guilty of insurance fraud.

AUTHORIZATION—In order to properly classify my application for life insurance, I authorize any and all licensed physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; insurance companies and their business associates and those persons or entities providing services to the insurer's business associates which are related in any way to their insurance plans; the Medical Information Bureau or other organization that has knowledge or records of me and my health to give such information to: (a) IA American Life Insurance Company; and (b) its reinsurers. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself. I may revoke the authorization by sending a written revocation to the Company address of 425 Austin Ave., Waco TX 76701. I understand that if I refuse to sign this authorization to release my complete medical records, my application for insurance with the Company will be rejected.

All said sources, except the Medical Information Bureau, are authorized to give records or knowledge such as statements regarding hobbies, employment, criminal records or medical history that might be required to determine eligibility for insurance to any agency employed by the Company to collect and transmit data. I authorize IA American Life Insurance Company to disclose any personal data gathered while processing this application. This data may be released to the following: (a) reinsuring companies; (b) the Medical Information Bureau; (c) other persons or groups performing services in connection with this application; or (d) any others to whom it may be lawfully required or authorized. This authorization shall remain valid for two years from this date. A copy of this authorization shall be as valid as the original.

I acknowledge receiving the Fair Credit Reporting Act Notice, MIB Pre-Notice, Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms, if applicable.

Proposed Insured Signature:_____ Date Signed: _____/_____/_____

Signed at _____ _____ _____

CITY STATE SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) SIGNATURE OF SPOUSE (IF APPLYING FOR COVERAGE)

AGENT'S REPORT

I certify that I have personally asked each question on this application to the proposed insured(s), I have truly and completely recorded on the application the information supplied by him/her, and I witnessed their signature. I certify that the Terminal Illness and Confined Care Accelerated Benefit Rider Disclosure Forms has been presented to the applicant, if applicable.

Does the proposed insured have any existing life or disability insurance or annuity contract? ..... ☐ Yes ☐ No

Is the proposed insurance intended to replace or change any existing life or disability insurance or annuity?..... ☐ Yes ☐ No

Mail Policy To: ☐ Insured ☐ Agent ☐ Owner Agent's remarks:_____

Agent (SIGNATURE) _____No: _____%_____ Agent (SIGNATURE)_____No: _____%_____

PREAUTHORIZATION CHECK PLAN - AUTHORIZATION TO HONOR CHARGE DRAWN

Insured_____Account Holder_____

Financial Institution (name/address)_____

Transit / ABA Number_____ Account Number_____ ☐ Checking ☐ Savings Requested Draft Day (1st-28th)_____

ATTACH VOIDED CHECK OR DEPOSIT SLIP

As a convenience to me, I hereby request and authorize you to pay and charge to my account amounts drawn on my account, whether by electronic or paper means, by and payable to the order of IA American Life Insurance Company, for the purpose of paying premiums on life insurance policy, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such charge shall be the same as if it were signed personally by me. This authorization is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

SIGNATURE (As on Financial Institution Records)_____ DATE_____

GL212AR

IA AMERICAN LIFE INSURANCE COMPANY
P.O. BOX 2549, WACO, TX 76702-2549

CONDITIONAL RECEIPT

NO COVERAGE WILL BECOME EFFECTIVE PRIOR TO POLICY DELIVERY UNLESS AND UNTIL ALL CONDITIONS OF THIS RECEIPT ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER THE TERMS OR CONDITIONS OF THIS RECEIPT.

ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK

Received of_____the sum of $_____as first payment on this application.

Date_____Agent_____

If (1) an amount equal to the first full premium is submitted; and if (2) all underwriting requirements, including any medical examinations required by the Company's rules, are completed; and (3) the proposed insured is, on the date of application, a risk acceptable for insurance exactly as applied for without modification of plan, premium rate, or amount under the Company's rules and practices, then insurance under the policy applied for shall become effective on the latest of (a) the date of application, or (b) the date of the latest medical exam required by the Company. THE AMOUNT OF LIFE INSURANCE, INCLUDING ANY AMOUNT IN FORCE OR BEING APPLIED FOR, WHICH MAY BECOME EFFECTIVE PRIOR TO THE DELIVERY OF THE POLICY SHALL IN NO EVENT EXCEED $150,000.00 (INCLUDING LIFE INSURANCE AND ACCIDENTAL DEATH BENEFITS).

If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid.

SERFF Tracking Number:	*APLE-127009065*	*State:*	*Arkansas*
Filing Company:	*IA American Life Insurance Company*	*State Tracking Number:*	*47836*
Company Tracking Number:	*GL212*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Family Solution*		
Project Name/Number:	*Family Solution/GL212*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

ReadCert.pdf

IA American Life Insurance Company
17550 N. Perimeter Drive, Suite 210
P.O. Box 27650, Scottsdale, AZ 85255-0131
888-473-5540 Toll Free
480-502-5088 Fax

CERTIFICATION OF READABILITY

IA American Life Insurance Company hereby certifies that the following form complies with state requirements for readability as follows:

LT301	Level Term Insurance Rider	55
CIB304	Children's Insurance Agreement	50
GL212	Family Plan Life Insurance Application	45

Michael L. Stickney
President

January 4, 2011